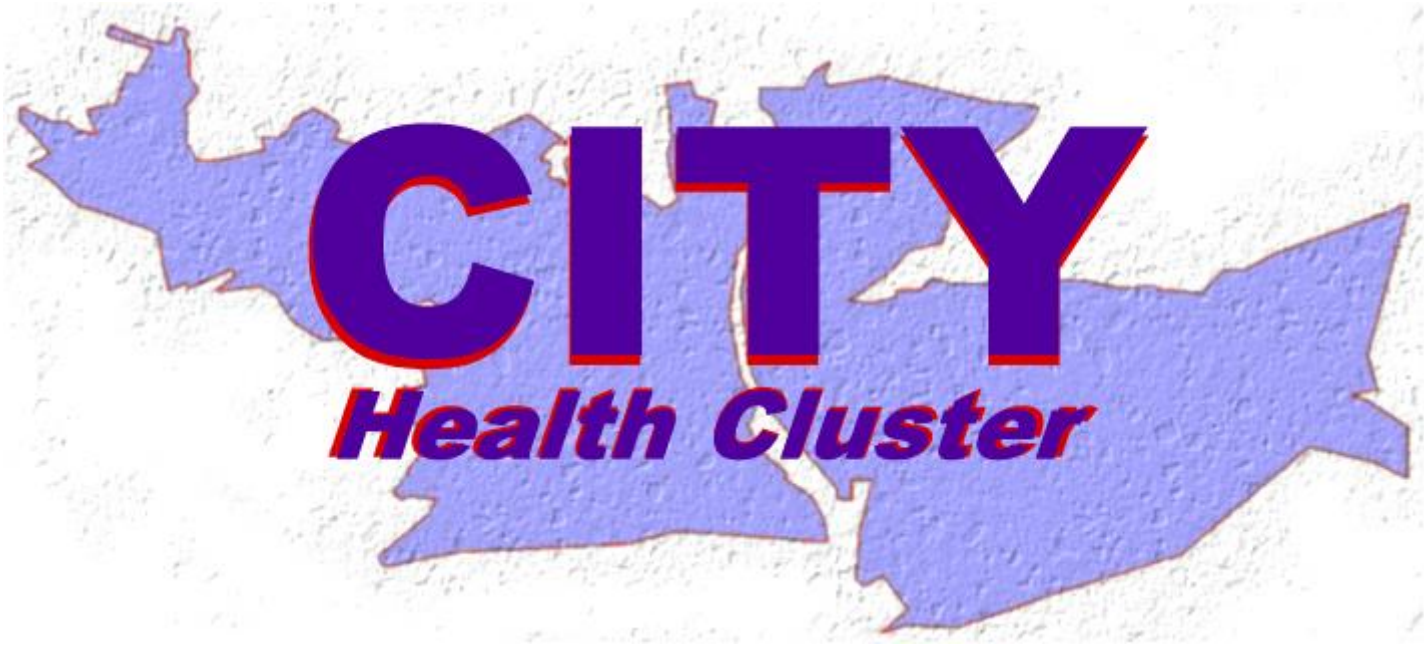
Three-Year Cluster Action Plan 2018 - 2021

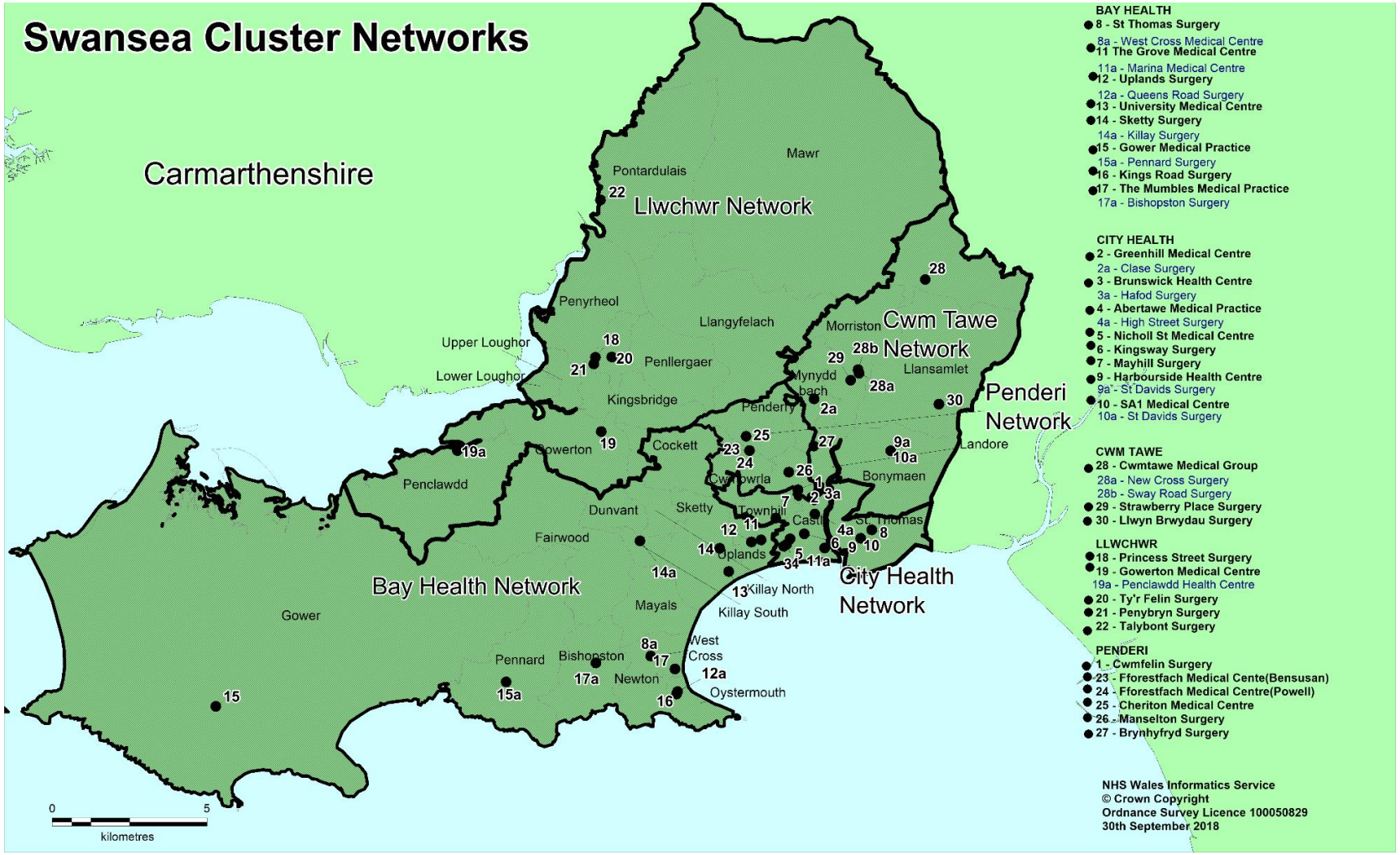
City Cluster



Welcome to the City Three Year Cluster plan, 2018 - 2021

1. *City Cluster Overview*

The City Cluster is one of five clusters in Swansea, geographically covering south east and central Swansea.



The City Cluster is made up of eight general practices working together with partners from social services, the voluntary sector, and ABMU Health Board, with practice populations ranging from 4331 to 10535, and a cluster total of 50,654 (October 2018 figures).

Clusters aim to work together in order to:

- *Prevent ill health enabling people to keep themselves well and independent for as long as possible.*
- *Develop the range and quality of services that are provided in the community.*
- *Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local needs.*
- *Improve communication and information sharing between different health, social care and voluntary sector professionals.*
- *Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.*

Through the delivery of their plans they work to meet the Quadruple Aims set out for Health and Social Care Systems in Wales in 'a Healthier Wales' (2018):

- ✓ Improved population health and wellbeing
- ✓ better quality and more accessible health and social care services
- ✓ higher value health and social care
- ✓ a motivated and sustainable health and social care workforce

2.1 Swansea wide 'Headline' Information

Population: 242,4000. High concentrations of population in and immediately around the City Centre, the adjacent wards of Cwmbwrla and uplands (6,800 people per square km, the highest density in the county) and also in Townhill and Penderi

Population has steadily grown between 2001 and 2015. Main driver of population growth in Swansea has been migration. Recorded live births has steadily risen since 2001 and number of deaths have fallen.

Life expectancy in Swansea is increasing: Average life expectancy for males is 78 (Wales 78.5) and 82.4 for females (Wales 82.3). This will impact significantly on the provision of health, social care and other public services in Swansea

Projected population Change: Welsh Government's latest trend based population projections suggest that Swansea's population will grow by 9% (21,600 people) between 2014 and 2039

2011 Census suggests that 14,326 people in Swansea were from a non white ethnic group: 6% of the total population and 20,368 (8.5%) of Swansea's Population were non white British. (above the Wales average (6.8%). Census data (2011) suggests the largest non white ethnic groups are: Chinese 2,052 (0.9%), Bangladeshi 1,944 (0.8%), Other Asian 1,739 (0.7%), Black African 1,707 (0.7%), Arab 1,694 (0.7%)

Welsh Language : Proportion of people able to speak Welsh in Swansea decreased from 13.4% (28,938) in 2001 to 11.4% (26,332) in 2011. A fall of 9% despite an increase in population.

Health and Attainment of Pupils in Primary Education Network (HAPPEN)

Established in April 2015, HAPPEN focuses on children in Swansea Schools aged 9-11 years who complete health and wellbeing assessments as part of the Swan Linx Project. Data is collected on body mass index, fitness, nutrition, physical activity, sleep, wellbeing, concentration and children's recommendations on improving health in their area. Cwm Glas, Terrace Road and St Thomas schools (three of the Primary Schools within the Network) have undertaken the study within the last two years, areas of interest are shown below:

	Cwm Glas %	Terrace Road %	St Thomas %	Swansea %
Sedentary Screen time for 2 hours or more a day	33%	32%	32%	31%
5 Portions of Fruit and Veg a day	25%	24%	26%	27%
At least 3 take aways a week	13%	16%	15%	18%
Physically active for 1 hr or more a day	28%	25%	25%	24%
Happy with family	96%	93%	94%	94%
Happy with Life as a whole	91%	89%	90%	91%

2.2 Our Local Health, Social Care and Wellbeing Needs and Priorities

Information has been collated on a wide range of health needs within the City Cluster area in order to develop the priorities for this plan.

Health Profiles

Obesity: 7.6% obesity rate, 3992 patients (Swansea average is 9%)

25.3% of smokers across the cluster population. Welsh Government have set a target of 16% by 2020.

The cluster has the 4th highest rate of lung cancer per 100,000 at 82.5 across the 11 clusters. (Lung Cancer profile 2015)

Asthma: 2nd highest rate 7.2% in Swansea (7.0%)

Influenza vaccination uptake of 68.1% in those 65 years and older (ranked 4th across 11 clusters), 51.8% in those under 65 years at clinical risk (ranked 1st across 11 clusters) and 48.2% for 2 & 3 year olds. PHW 2017/18 (Welsh Government target is 75%)

The cluster is the lowest for the uptake of childhood immunisations by the age of 4yrs at 78.21% (Welsh Government target is 95%)

City has the lowest uptake in ABMU (PHW 2016/17) for all four screening programmes:

- 3656 eligible for bowel screening, 1628 were screened (44.5%). Target 60%
- 11857 are eligible for cervical screening, 8216 were tested (69.3%). Target 80%
- 219 eligible for AAA screening, 161 people were tested (73.5%). Target 80%
- 5763 eligible for breast screening, 3787 were tested (65.7%). Target 70%

An estimated 4,653 of Swansea's adult population have a learning disability; of this number 969 (20.8%) have a moderate or severe learning disability.

Around 32,200 people aged 16 or over in Swansea may have one Common Mental Disorder e.g. anxiety depression and OCD. Nearly half this number (14,573) have two or more conditions, along with those experiencing borderline personality disorder (913), antisocial personality disorder (703) and those experiencing psychosis (811). City Health has the highest rate in Swansea rate of 1.5% for those registered as having a mental health condition. 6 of the 7 practices reporting the highest burden are within City Cluster.

Alcohol reported intake for those 16+years is 71.97%. This is the lowest in the 5 clusters. ABMU average is 76.58%

71.9% of registered patients aged 16+ had been recorded as having drunk alcohol in the last 7 days

Key Population Features

High deprivation levels; with 24,833 (49%) residents living in the most deprived fifth of areas in Wales

A high proportion of young people due to the large student population.

High level of asylum seeker and multi-racial/multi-cultural groups.(more than double the Swansea average)

There are slightly higher number in City Cluster (24.2) than the Swansea average (23.3%) living with a disability

12.4% are young parents. Swansea average 11.7%

29.2% of those living within City Cluster have no qualifications (Swansea 23.9%)

16.8% of patients are aged 65+ (19.2% across Swansea) and 7.8% of patients are 75+ (8.9% across Swansea)

This area consists of 22 LSOAs in the city centre area and adjacent urban areas to the north, west and east; across both sides of the River Tawe

Many of the men released from HMP Swansea are provided housing within the City Cluster.

Cluster Area features

Major employers: City & County of Swansea, BT, Grwp Gwalia Cyf, Coastal Housing, University of Wales Trinity St. David, HM Prison, Tesco, Sainsburys, Marks & Spencer, Debenhams, other city centre businesses *(west side of the River Tawe)*, Admiral Insurance, Associated British Ports,

4 General dental practices
1 specialist Orthodontic Practice
1 specialist dental practice (sedation and oral surgery)

Across Swansea:
- Great diversity of landscapes, habitats, species and geology (50% of the county is of significant ecological value.)

Good level of accessible green space across most of the county (Open Space Assessment) 15 Green flags for parks and 7 community spaces

Population and Community Assets

Active Community and Voluntary Organisations.

Leisure centres
Entertainment venues
Libraries
Community Hubs
Beach access
Football and Rugby stadiums
University
Kilvey Country Park
Access to the River Tawe and the Marina

City regeneration, together with the development of continuous cycle routes along the bay and road improvements to reduce congestion along Fabian Way have facilitated easier and safer access to the city.
Road Safety Wales raise awareness in new drivers of the main traffic accident causes.

Service Demands

Highest number of A&E attendances of any cluster in Swansea at 164.90 per 1K (16584 patients)

GP OP referrals, 2nd highest in number of referrals in Swansea (4142) 84.54 per 1000.

The second highest rate in Swansea of emergency inpatient admissions

The highest rate of prescription of anxiolytics and hypnotics, antidepressants, opiod analgesics, tramadol, NSAIDs in Swansea

The long-term general trend of an ageing population, which stands at 78.0 years for males in Swansea (Wales 78.5) and 82.4 for females (Wales 82.3) and is likely to impact on health and wellbeing services. ONS

OOH attendance between 1st September 2017 and 31st August 2018, rate per 1000 was 84.52. This is the second highest within the 5 clusters

Other key Influencing Factors

The City and County of Swansea declared parts of the lower Swansea Valley an Air Quality Management Area on the 12th September 2001. The area is cited as the Hafod Air Quality Management area - City and County of Swansea (Hafod Air Quality management Area (NO2)) Order , much of which sits within the City cluster area.

LDP Strategy- Plans to extend further the Development of the University and Student Accommodation.

Bus fares have fluctuated a little but generally the trend has been upward, worsening the poverty premium, (the amount people living in poverty have to pay for essential items).

Public Service Board, Local Wellbeing Plan Focus:

Early years: Making sure children have the best start in life.
Live Well. Age Well – making Swansea a place to live and age well.

Working with nature- improving health, supporting biodiversity and reducing our carbon footprint
Strong communities- supporting communities to promote pride and belonging.

PSB aims to make all services work together by sharing resources, assets and knowledge

2.3 Antibiotic Prescribing:

Detailed below is the most current figures for antibiotic prescribing within the Swansea Cluster areas. Nationally there was a 2.2% reduction in antibiotic prescribing levels for the same period City increased its antibiotic prescribing level by 0.45%.

Entity	Items Apr 17 - Mar 18	Items Apr 16 - Mar 17	Items % Variation	Items Difference
City Health (Swansea)	35,303	35,144	0.45%	159

2.4 GP Disease Register Information

Disease Register	City Register Total 2018 (%)	Swansea %	ABMU %	Trends/Highlights
Asthma	3700 (7.2%)	7.0	7.4	2nd highest in Swansea
Cancer	(2.1%)	2.7	2.9	Lowest percentage
COPD	1311 (2.6)	1.9	2.2	Highest % in Swansea, 4th highest in ABMU
Mental Health	767 (1.5%)	1.1	1.1	Highest % in Swansea
Diabetes	3119 (6.2%)	5.6	6.2	Higher than Swansea average
Palliative care	0.2	0.2	0.2	Joint 2nd highest

3. Strengths Weaknesses Opportunities and Threats (SWOT) analysis: City Health Cluster

Cluster SWOT Analysis

Strengths

Recognising Network population needs and taking measures to support

Building on relationships with Secondary Care, Third Sector, Local Authority and other partners

Cluster Network maturing and developing

Self-assessing and acknowledging gaps in provision and acting to fill i.e. Implementation and Business Development Manager, Paramedic

Strong leadership by the Cluster Lead
Capacity to deliver - Implementation and Business Development Manager

Weaknesses

Lack of time to develop initiatives

Staff working at full capacity

Difficulty regarding recruitment and retention of GPs

Lack of/Increasing cost of locums

Indifference/Lack of genuine participation

Consistency in ensuring that the cluster message is relayed back to GP's within the practice and that their thoughts are fed into the cluster

Opportunities

Tailor Protected Learning Time Sessions to attract and inform staff in order for primary care teams to engage with new ways of working and direction of travel for the cluster

Strengthen links with Secondary Care, Third Sector, Local Authority and other Partners

Link with neighbouring Clusters for mutual benefit

Tailor the Plan further to the needs of the network population (substance misuse/mental health/asylum seekers)

Access external funding sources

Threats

LDP shows proposed additional 1700 houses being built in the cluster area.

GP retirement/ recruitment issues

Staff shortages in other areas

Staff morale/wellbeing

Practice sustainability

Reduced allocation of budget by Welsh Government

Change in government policy regarding clusters

4. Cluster Vision

In May 2018, the City Cluster jointly agreed a Cluster Vision for the next three years. The Vision sets out how this Cluster sees its role in providing Health, Social Care and Wellbeing with and for the population of the City area and its practices.

"City Health Cluster has a vision to improve its patient's health and wellbeing outcomes alongside focusing on the future sustainability of General Practice. We will achieve this by embracing and encouraging multi-agency and peer collaborative working, participating in and promoting education, sharing our skills and resources across our Cluster efficiently and effectively"

5. City Cluster Practice Priority Issues

Practices have expressed a range of areas which are a priority for them in delivering a sustainable and effective primary care service. These issues have also been taken into account in developing the City Cluster Plan.

Our Cluster Plan

Strategic Aim 1: To understand and highlight actions to meet the needs of the population served by the Cluster Network with a preventative approach

Our three year focus:

- Address obesity for school aged children, adults and elderly
- Improve the pace of reduction of smoking rates and respiratory disease for the City Health population

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
1.1	**Obesity** Work with Third Sector – to develop a comprehensive range of information to support patients.	GPs Practice Managers ABMU HB	March 2019 and ongoing	Reduced levels of obesity resulting in greater wellbeing	Limited resources for supporting patients outside of healthcare environment.	
1.2	Establish city centre walking groups to support physical activity levels	All Cluster members, NIBDM	July 2019	Clinicians able to refer to more timely closer to home services. Increased physical activity among practice populations.	Limited peer/communal activity for patients to engage in regarding increasing physical activity and diet.	
1.3	Explore potential of exercise therapist for Cluster	All Cluster members, NIBDM, HB	Ongoing to March 2021	Enhanced level of service available for patients to improve physical activity levels Improved physical and mental health outcomes for patients Reduced demand on primary and community services	NERS referral is current option for practices, together with Weight Watchers Vouchers.	
1.4	**Smoking:** Increase use of CO monitors in collaboration with ASH	GP practices	Ongoing	Increase smoking cessation service uptake.	All practices have received CO monitor, including branch practice.	

				Increased use of CO monitors recorded and fed back to practices.	Event held by PHW and ASH Wales.	
1.5	**Respiratory:** Rollout of Interface Pharmacy Group inhaler reviews to all 8 practices; review of COPD patients on triple therapy inhalers Improving patient education around use of inhalers and condition management	GP practices, NIBDM	March 2021	Improved prescribing savings Better control of condition	2 practices have undertaken so far	
1.6	Flu vaccinations targeted programme: Undertake MDT flu vaccination programme over 2 dedicated weeks for housebound patients in the Cluster	Cluster Pharmacist, Cluster Paramedic	November 2018	Increased uptake of flu vaccinations in hard to reach groups Vulnerable patients less likely to become seriously ill. Reduced demand on primary and unscheduled care.		

Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients including any agreed collaborative arrangements

Our three year focus:

- Ensuring practice teams are fully supported to deliver practice and cluster service requirements
- Reducing the administrative burden for practices

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
2.1	Explore the potential for the Cluster to develop its own administrative hub for core duties such as prescribing	NIBDM, Cluster Lead	July 2019	Implementation of a prescribing hub. Time saved for GPs.	Individual practices/GPs undertaking all prescribing related activity	

				Increased prescribing savings.		
2.2	Undertake a skills audit for staff to identify training and development needs against practice, organisational and Cluster needs	NIBDM, all practices	May 2019	Team skills expanded - supporting them to meet the needs of the practice/depts./organisations All staff provided with access and capacity to undertake relevant training programmes	Practices focus on own requirements only.	
2.3	Agree to develop a workforce plan for Cluster: Administration Nursing & paramedical Clinical	All practices, Cluster members, HB, NIBDM	Sept 2019	Practice sustainability, clear plan to ensure appropriate workforce in place to deliver prudent healthcare. Better access for patients Cross-practice working opportunities maximised.	Progress has been made to deliver a strong MDT, opportunities for longer term planning	
2.4	Collaborative working - Develop list of enhanced services for cross-practice referral	NIBDM, HB	March 2018	Access to a variety of enhanced services for patients.		

Strategic Aim 3: Planned Care - to ensure that patient's needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms. To highlight improvements for primary care/secondary care interface.

Our three year focus:

- Increase the screening rates significantly within the Cluster, reducing variation, for Bowel, AAA, Cervical and Breast Screening by 2021.
- Improve Cluster access to imaging to improve cancer diagnosis, with focus on radiology

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating

3.1	**Cancer:** Improve Cluster access to imaging to improve cancer diagnosis, with focus on radiology by: - Closer liaison with the MacMillan GP Lead - Training of GPs in all practices on Red Whale course - Undertaking peer review where possible	GP practices, Cluster Lead, Secondary Care (radiology), NIBDM	March 2021	Improved treatment times and outcomes for patients diagnosed with cancer Less unnecessary variation across practices		
3.2	Undertake training and education programme to upskill non-clinical staff on improving screening uptake (through Cancer Research Wales)	GP practices	July 2019	Improved screening rates.	Lowest rates of screening uptake across the ABMU Clusters.	

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management. To address winter preparedness and emergency planning.

Our three year focus:

- To reduce the high levels of GP Out of Hours attendance from a level of 84.54 per 1000 patients.

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
4.1	Paramedic, Pharmacist and LAC project	Cluster Lead, HB, LAC Manager, Cluster MDT, NIBDM	Sept 2019	Key outcome measures include: Improved Multi-disciplinary team effectiveness and seamless, cross organisational working relationships,	Interview with Health Foundation for project funding scheduled 12th November.	

				Reduced attendances at GP practices; Patient numbers attending the Community Clinic; Patient Feedback on the service provided; Identification of previously undiagnosed issues eg: Hyper tension, high blood pressure, pre diabetes; Number of 'social prescribing' referrals to community services.		
4.2	Implement training in Care Navigation for receptionists	NIBDM, practices, HB	March 2020	Patients better able to have their needs met before seeing a GP, better understanding of their care pathways. Reduced unnecessary contacts with GPs		
4.3	Promote Common Ailments Service	Health Board Community Pharmacy team, Practices, NIBDM	Ongoing	Better access for patients to treat common ailments. Increased time for GPs to undertake complex consultations.		
4.4	Explore opportunities to adopt the 24/7 GP self-help website within the Cluster	NIBDM, HB	March 2018	Improved access to information for patients, better enabled for self-care.	Limited practice/Cluster specific online support	
4.5	To ensure effective planning is in place for the winter season to ensure continual increase in uptake of Flu Vacs and advanced promotion of self care - *Practices to host flu parties* - *Vacs for Housebound patients to continue* - *Publicity/self care info for patients including myth busting*	GPs Practice Managers	Sept /Oct 2018 and ongoing to 2021	High levels of patients including older and housebound patients,at risk patients and children immunised against flu. Patients 'health literate' with regard to myths surrounding flu and actively seeking flu vacs.	Cluster Flu Vaccination Figures based on PHW Data 2017/18 included in Health Profile section	

	- *Consider other methods and channels of publicising/promoting the benefits of the flu vacs* - *See 1.6 for designated MDT programme*					

Strategic Aim 5: To develop the Cluster as a structure for delivery of identified priorities.

Our three year focus:

- Identify cluster specific benefits and scope potential for formal collaboration
- Identify key service areas the cluster would like to become

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
5.1	**Vision, Purpose, Functions and strategy** Agree *operational* model for Cluster that best meets needs of Cluster	Cluster Lead Lead GPs PMs, HB	Dec 2019	Best support possible in place for Cluster practices, enabling better and continued access for patients. Cluster members able to deliver and provide clarity regarding roles and responsibilities.	Cluster has discussed potential benefits of working more closely together, yet to look closely at options available	
	Develop potential for planning Cluster spend across 3 year period		Ongoing	To have clear aims, objectives and vision of areas in which City Health Cluster wish to implement change and develop existing services to enable planning and resource identification	Cluster vision set, priority areas of focus. 18-24 mth spend plans in place.	

5.2	**Communication and Engagement** Establish Cluster communications strategy, identifying key stakeholders to influence to maximise impact, including sharing best practice delivered in City Health	Cluster Lead Lead GPs, NIBDM, PMs, HB	June 2019	Strategic stakeholders aware of key cluster programmes. Cluster members better aware of outcome from use of time and resources.	Comms made on opportunistic basis eg via WG comms scheme through Health Board.	
5.3	**Employment and Training Arrangements** To ensure practices within the cluster have appropriate employment and training arrangements in place, including clarity on indemnity issues for all professional groups Robust processes for cluster workforce planning and OD.	NIBDM, Practices, Cluster Lead	March 2019	Sustainable MDT working at Cluster and practice level. Safe and effective care delivered by the most appropriate professional. Safe management of risk. Staff equipped to work to highest level. Improved service to patients	Clusters across Wales identifying varying solutions to employment of MDT staff. Varying levels of team training across practices in cluster.	
5.4	**Infrastructure, Support and Leadership** Allocate protected time and headspace for innovation for cluster leadership roles Review of cross cluster IT, Estates infrastructure to meet aims Implement mobile technology to support Cluster working, working closely with ABMU for Digital Mobilisation	Cluster Lead Lead GPs PMs, HB Cluster Lead Lead GPs PMs, HB, NIBDM Cluster Lead Lead GPs PMs, NIBDM	Ongoing, commencing Jan 2019 Dec 2019 Dec 2019	Cluster programmes able to be delivered more quickly, time for cluster lead to further consider strategic direction. Better use of current resources across the cluster Delivery of services effectively and efficiently using modes of technology	Cluster Lead allocated ½ day per week to deliver all cluster work. Clear understanding of resources to be considered in planning of services. Good use of mobile IT to benefit patient care and improve workflow not yet considered at Cluster level	

5.5	**Addressing Population Needs** • Enable practice and team time to collate and set out data for external evaluation • Identify and secure additional funding streams	Cluster Lead Lead GPs PMs, HB, NIBDM	Dec 2019	Demonstration of effectiveness of Cluster programme. External funding available for the cluster to deliver services meeting its identified priorities	Practices identifying time within current constraints. Cluster has commenced with some level of application for additional external funding but little leverage of additional funding and resources currently achieved	
5.6	**Integration and Partnership** • Draw up a code of conduct between cluster partners and organisation • Understand local assets and how to access local services	Cluster Lead Lead GPs PMs, HB, NIBDM	May 2019	Cluster partners understand their respective roles Patients and citizens aware of local assets and benefits to them of their use	Code of Conduct required. Local assets not extensively utilised on a Cluster basis	
5.7	**Quality Assurance** • Establish clear cluster accountability mechanisms for agreed work programmes • Establish business planning cycle for cluster to prioritise cluster projects and planning spend • Ensure Cluster compliant with GDPR for Cluster based/delivered activity	Cluster Lead Lead GPs PMs, HB, NIBDM	May 2019	Cluster programmes delivered more rapidly, with engagement. More vigorous approach to delivering cluster strategic direction and minimising likelihood of slippage, ensuring most effective use of funding. All staff will receive GDPR training	Lack of clear resource/capacity for implementation. In place on an ad hoc basis in relation to cross cluster issues. Training resource to be identified	

Strategic Aim 6: Other Cluster and area specific issues

Our three year focus:

- To improve the low uptake of immunisations and vaccinations for children in City Health

No	What action will be taken	Responsible for delivering	When will it be completed	What will success look like? What will the outcome be for patients?	Current position	RAG Rating
6.1	Imms and Vacs – Develop a project on childhood vacs, including an audit of those not being vaccinated and develop a plan to improve figures.		March 2021	Improved rates of vaccination for children.		
6.2	Support the mainstreaming of services via the business case application process through 'Balancing the System – shifting resources from secondary to primary care' for: **Mental Health Services for Tier 0, Pharmacist Provision Physiotherapy** on a Cluster basis	Cluster Development Managers, Cluster Lead	Oct/Nov 2018 and ongoing	Services mainstreamed, resources transferred and Cluster funds released where relevant	Pharmacy outline case summarised for consideration by ABMU Strategy and Finance Depts. Physiotherapist preferred option model being costed. Mental Health Options appraisal being undertaken Three cases to be included in IMTP for the Unit	

6. Cluster Finance Statement

The City Cluster has a financial allocation from the Welsh Government of £165,073. In addition Clusters have access to other funding streams such as through the Health Board delivered PMS+ scheme.